Date of Hearing: April 6, 1999

ASSEMBLY COMMITTEE ON JUDICIARY
Sheila James Kuehl, Chair
AB 525 (Kuehl and Thomson) – As Amended: April 5, 1999

SUBJECT: HEALTH BENEFITS: ACCESS TO REPRODUCTIVE HEALTH SERVICES

KEY ISSUES:

1) SHOULD HEALTH PLANS WHOSE PROVIDERS RESTRICT ACCESS TO REPRODUCTIVE HEALTH SERVICES BE REQUIRED TO CONTRACT WITH AT LEAST ONE OTHER FACILITY IN THE SAME GEOGRAPHIC AREA THAT PROVIDES SUCH SERVICES IN ORDER TO ENSURE ACCESS TO THESE CRITICALLY NEEDED SERVICES?

2) SHOULD HEALTH PLANS BE REQUIRED TO INFORM CONSUMERS CONCERNING RESTRICTIONS ON ACCESS TO REPRODUCTIVE HEALTH SERVICES SO THAT CONSUMERS CAN MAKE MORE INFORMED DECISIONS WHEN CHOOSING THEIR HEALTH CARE PROVIDERS?

3) SHOULD THE ATTORNEY GENERAL BE GIVEN NEW POWERS TO CONTROL HOSPITAL MERGERS IN *NONPROFIT-TO-NONPROFIT* TRANSACTIONS AND BE REQUIRED TO CONSIDER THE IMPACT OF SUCH MERGERS ON PATIENT ACCESS TO REPRODUCTIVE HEALTH SERVICES, AS WELL AS EMERGENCY AND INDIGENT CARE SERVICES?

4) SHOULD HEALTH CARE FACILITIES THAT RECEIVE TAXPAYER DOLLARS THROUGH THE CALIFORNIA HEALTH CARE FACILITIES FINANCING AUTHORITY AND THE CAL-MORTGAGE LOAN INSURANCE PROGRAM BE REQUIRED TO GIVE ASSURANCES THAT THE FULL RANGE OF REPRODUCTIVE HEALTH SERVICES WILL BE MADE AVAILABLE IN THE COMMUNITIES THEY SERVE, EITHER THROUGH THEIR OWN FACILITIES OR BY PARTNERING WITH OTHERS WHO WILL PROVIDE THESE SERVICES?

5) SHOULD UNIFORM ANTI-DISCRIMINATION STANDARDS BE APPLIED IN HEALTH INSURANCE AND HEALTH FACILITIES FINANCING PROGRAMS?

SUMMARY: Seeks to protect patient access to the full range of reproductive health services, as well as emergency and indigent care services, and prohibits discrimination in health insurance and health facilities financing programs. Specifically, this bill:

1) Requires health plans (including commercial HMOs and Medi-Cal managed care plans) whose providers restrict access to reproductive health services to contract with at least one other facility in the same geographic area that provides those services. It also requires HMOs to ensure that voluntary tubal ligations be made available at the time of labor and delivery when medically appropriate.

2) Requires health plans to inform consumers concerning restrictions on access to reproductive health services, including any hospitals, medical groups and other health care providers which might deny or delay access to these services.

3) Gives the Attorney General (AG) new powers to control hospital mergers in nonprofit-to-nonprofit transactions. It also requires the AG's review of hospital mergers to consider the impact of the merger on patient access to the full range of reproductive health services, as well as emergency, urgent care and indigent care services.

4) Requires that, in order to receive taxpayer dollars through the California Health Care Facilities Financing Authority Act and Cal-Mortgage Loan Insurance programs, hospitals and other health care providers licensed to provide reproductive health services must first guarantee they will make available all reproductive health services, either through their own facilities or by partnering with others who will provide these services.

5) Prohibits discrimination on the basis of race, color, religion, national origin, gender, or sexual orientation in the availability and the type of health insurance coverage offered by indemnity, Knox-Keene, and Medi-Cal managed care plans, as well as in the California Health Care Facilities Financing Authority Act and the Cal-Mortgage Loan Insurance program.

6) Respects religious health care providers' rights to adhere to religious principles and does not require religious hospitals to provide services that are inconsistent with their religious beliefs.

EXISTING LAW:

1) Provides, under the Knox-Keene Health Care Service Plan Act of 1975, for the licensure and regulation of health care service plans (HMOs) by the Commissioner of Corporations. The Knox-Keene Act requires, among other things, that HMOs must:

   a) use disclosure forms or other materials containing designated information about the benefits, services and terms of the plan, including the principal benefits and coverage of the plan, and the exceptions, reductions and limitations that apply to the plan.

   b) describe how participation in the plan may affect the choice of physician, hospital or other health care providers, and other specified information.

   c) meet certain requirements, including providing to subscribers and enrollees basic health care services. (Health and Safety Code Section 1340 et seq.)

2) Provides for the regulation of insurance by the Insurance Commissioner, including disability insurers, insurers issuing policies of disability insurance, and self-insured employee welfare benefit plans that cover hospital, medical or surgical expenses. It also circumscribes the authority of the Insurance Commissioner in approving disability insurance policies and requires disability insurers to disclose, among other things, the principal benefits and coverage of the plan and the exceptions, reductions, and limitations that apply to the plan. (Insurance Code Section 10110 et seq.)

3) Provides, under the Public Employees' Medical and Hospital Care Act, health benefits plan coverage for public employees and annuitants meeting the eligibility requirements prescribed by the Board of Administration of the Public Employees' Retirement System (CalPERS). (Government Code Section 22754 et seq.)

4) Provides for the Medi-Cal program, which is administered by the State Department of Health Services, under which medical benefits are provided to public assistance recipients and certain other low-income persons. Under existing law, Medi-Cal services may be provided to a beneficiary or eligible applicant by an individual provider, or through a prepaid managed health care plan, pilot project, or fee-for-service case management provider. (Welfare and Institutions Code Section 14000 et seq.)

5) Requires a nonprofit health facility to provide notice to, and obtain the consent of, the AG prior to the sale, transfer or lease of assets to a for-profit or mutual benefit corporation when a material amount of the nonprofit's assets are involved in the transaction. (Corporations Code Section 5914 et seq.)

6) Empowers, under the California Health Facilities Financing Authority Act, the California Health Facilities Financing Authority (CHFFA) to finance projects of health facilities that are operated by a city, county, a district hospital, or a private, nonprofit corporation or association. It also authorizes CHFFA to issue revenue bonds for this purpose, and requires borrowers to give reasonable assurance to the authority that the services of the health facility will be made available to all persons residing or employed in the area served by that facility. (Government Code Section 15430 et seq.)

7) Provides, under the California Health Facility Construction Loan Insurance Law (also known as the Cal-Mortgage Loan Insurance Program), for an insurance program for public and nonprofit health facility construction, improvement, and expansion loans. (Health and Safety Code Section 129000 et seq.)

8) Does not apply uniform anti-discrimination standards in health insurance and health facilities financing programs.

FISCAL EFFECT: Unknown

COMMENTS: According to the authors, AB 525, also known as the "1999 Healthcare Access bill," was introduced to protect patient access to a variety of reproductive health care services, as well as emergency care and indigent care services. The authors state that in today's managed care environment, more and more hospitals are merging and entering into other business deals in order to cut costs. For example, in California, the largest owner of hospitals (and the biggest merger participant) is Catholic Healthcare West, with 46 facilities statewide. Tenet Healthcare, by comparison, owns 42 acute care hospitals in California.

When a health care provider is a religious entity, patient access to the full range of reproductive health services can be threatened. Catholic hospitals, for example, must adhere to a strict set of ethical guidelines called the Ethical and Religious Directives ("the Directives") which severely limit access to the

full scope of reproductive health services, especially to women. The Directives prohibit Catholic facilities from providing services such as fertility treatments, contraception, vasectomy and abortion. Generally, even rape victims are refused emergency contraception. In addition, under the Directives, women are prevented from receiving needed tubal ligations immediately after delivery, which physicians believe is the best time for such a procedure to avoid greater health risks associated with multiple surgeries.

The authors state that when Catholic and non-Catholic hospitals merge, these Directives usually are imposed on the non-Catholic provider as a condition of sale. That can mean either the loss of critically needed reproductive health services in the community or continued restrictions on access. For example, the authors point to the recent merger in Los Angeles between Queen of Angels Hospital and Tenet Healthcare, where Tenet, a non-religious provider, agreed to continue the ban on reproductive health services for the next 20 years.

The authors note that Catholic health networks are not alone in limiting access to the full scope of reproductive health care services. According to the authors, other religious entities that own hospitals and health facilities also limit access. For example, the authors state that Adventist Health system owns and manages 20 hospitals and a number of clinics statewide, none of which provide needed access to abortions.

Unfortunately, the authors contend, this access problem extends far beyond the hospital doors. In some cases, religious hospitals purchase outpatient facilities, clinics and physician networks, blocking all of these facilities and providers from delivering needed reproductive health services. Even doctors who are tenants in medical buildings owned by religious organizations can be made to follow restrictions on access to these services as a condition of the lease agreement. They also note these policies regrettably fall most harshly on women, whose reproductive health service needs more often require hospital services.

Overview of bill. According to the authors, AB 525 seeks to prevent further losses in access to reproductive health services in the following five ways:

First: AB 525 would require all health plans--including commercial HMOs and all Medi-Cal managed care plans--to guarantee that patients have access to the full range of reproductive health services within the HMO's provider network. This includes guaranteeing access to voluntary tubal ligations at the time of labor and delivery.

Second: AB 525 requires all health plans to inform consumers in their marketing and enrollment materials about how they may access the full scope of reproductive health services and about any limitations on access to these services.

Third: AB 525 gives the AG new authority to scrutinize nonprofit-to-nonprofit hospital mergers and to disapprove mergers which would have the effect of denying patients access to the full range of reproductive health services, as well as emergency care and indigent care services. *Currently, the AG may not consider the impact on patients of the lack of access to these critical health services.* These same standards would be added to the AG's scrutiny of nonprofit to for-profit mergers as well.

Fourth: AB 525 requires health facilities that receive taxpayer dollars through public bond and loan programs to ensure access to all reproductive health services, either through their own facilities or by partnering with others who will provide these services.

Fifth: AB 525 prohibits discrimination in all forms of health insurance and in public financing of health facilities. It also places an affirmative obligation on the Insurance Commissioner and on the California Medical Assistance Commission to ensure that health policies and Medi-Cal contracts that they approve and/or negotiate prohibit such discrimination. *Currently, there are no uniform anti-discrimination provisions in health insurance and health facilities financing programs.*

Bill respects rights of religious health care providers. The authors stress that nothing in AB 525 would force religious hospitals to provide services that are inconsistent with their religious beliefs. Rather than require religious health care providers to violate their religious tenets, the bill only requires that religious hospitals partner with others or otherwise arrange for the provision of reproductive health services if they elect to receive bond funds and mortgage loan insurance through state financing agencies.

According to the authors, "the Healthcare Access Bill will help to assure that women who join HMOs or Medi-Cal managed care plans will receive the full, uninterrupted range of reproductive health services. This bill is especially necessary to protect the working poor and those who are struggling economically from a threatened diminishment of reproductive health service due to the mergers of hospitals that have differing health care approaches. AB 525 will not force a single doctor or hospital to provide services in which they do not believe. However, it is not acceptable to have rape victims refused emergency contraception or to have a mother who has just given birth, and whose doctor has advised her to have a tubal ligation, forced to undergo a dangerous second surgery. AB 525 simply guarantees that patients will know what's available to them and be able to secure the service they need when they need it."

Background. The following examples of the scope of the growing problem of restricted access to needed reproductive health services, together with some key statistics regarding the increased market share of religious health care providers, may be helpful in putting this legislation in context.

The Impact of Restrictive Religious Rules On Health Care In California. The following examples demonstrate the increasing difficulties facing women in California in accessing reproductive health services due to the expansion in the number of health care providers which abide by religious directives that restrict access to these critically needed services.

- In Lassen County, Lassen Community Hospital, in Susanville, is a "sole provider" hospital for the area. Although it has a secular name, it is a Catholic Hospital which provides no emergency contraception to rape victims and reportedly refuses to provide a referral to another facility for such help. (Catholics for a Free Choice, *"Caution: Catholic Health Restrictions May Be Hazardous to Your Health,"* 1999)

- In Los Angeles and Orange County, Catholic Healthcare West merged with Unihealth, purchasing eight hospitals. Unihealth is a secular health system, yet it reportedly eliminated all of its in-vitro fertilization and abortion services as a condition of the merger. (Los Angeles Times, *"Women Protest Church Takeover of Hospital,"* Nov. 17, 1998)

✍✍In Santa Rosa, a doctor who tried to rent space in a medical office building was apparently told to sign a lease requiring her to adhere to all of the local Bishop's prohibitions on reproductive healthcare because the building is owned by a Catholic Health System. (Sacramento Bee, *"Healthcare Ties That Bind,"* July 18, 1998)

✍✍In Humboldt County, a woman apparently cannot receive a needed tubal ligation at St. Joseph's Hospital unless her medical records show a severe medical condition, a history of suicide, or that the pregnancy "will precipitate mental dysfunction." (St. Joseph Health System, *"Policy on Tubal Ligations,"* St. Joseph Memorandum, August 12, 1996)

✍✍In June 1998, the Beach Cities Health District, a government entity, leased space in the South Bay Medical Center to Little Company of Mary, who reportedly provides no reproductive health services and demanded a lease provision that will allow it to terminate its lease if anyone provides prohibited health services, including contraception, anywhere else in the building. (Los Angeles Weekly, *"Higher Calling,"* July 16, 1998)

✍✍In Sonoma County, a busy medical group that provides care to more than 100,000 patients was recently purchased by a religious health system, and the group is now reportedly prohibited from providing abortions. Consumers apparently have no way of knowing of these restrictions when they choose a doctor in that group. (Sonoma County Independent, *"The End of Choice?"* Feb. 25 - Mar. 3, 1999)

Some Key Religious Health Care Statistics. The following statistics reveal a dramatic increase in the market share of religious health care providers, which, in turn, has resulted in a significant decline in patient access to the full range of reproductive health services.

✍✍Nationally, Catholic institutions control 600 hospitals, 140,000 beds and $40 billion in revenue. That compares to 300 hospitals, 60,000 beds and $14.5 billion in revenue for Colombia/HCA Healthcare. (San Francisco Daily Journal, *"Where Religion and Abortion Collide,"* Feb. 2, 1999)

✍✍Reproductive health services were reduced or eliminated in 35 of 71 religious hospital mergers in the country from 1990 to June 1998. (Sacramento Bee, Forum, *"Family Planning, Abortion Tougher to Obtain,"* March 28, 1999)

✍✍In 1998, there were 91 Catholic hospitals designated as "sole provider" hospitals in the country. Sole provider hospitals receive higher government reimbursement for services because they are the only hospitals serving their communities, but they are not required to provide reproductive health services. (Catholics For a Free Choice, *"Caution: Catholic Health Restrictions May Be Hazardous to Your Health,"* 1999)

✍✍The largest hospital operator in California is Catholic Healthcare West, with 46 hospitals, compared to Tenet Healthcare's 42. (Modern Healthcare, *"Unihealth Hospitals to Merge with CHW,"* Oct. 19, 1998)

✍✍The largest single borrower of bond proceeds from the California Health Facilities Financing Authority is Catholic Healthcare West. They have borrowed nearly $1.6 billion. (*California Health Facilities Financing Authority Report,* July 31, 1998).

✍✍Of 51 Catholic Hospitals surveyed in California, none permitted emergency contraception to rape victims, 44 reported they will not provide emergency contraception, and 7 reported they had no policy. (Catholics for a Free Choice**,** *"Caution: Catholic Health Restrictions May Be Hazardous to Your Health,"* 1999)

Comparison of this bill with AB 254. AB 254 (Cedillo), which is also scheduled to be heard by the Assembly Judiciary Committee on April 6, 1999, contains similar provisions expanding AG authority over hospital mergers to include nonprofit-to-nonprofit hospital transfers. This bill's AG provisions are complimentary to, and not in conflict with AB 254. Although there are some minor variations, the principal difference between these two bills is as follows. This bill requires the AG's review of a hospital merger to specifically consider the impact of the merger on patient access to the full range of reproductive health services, as well as emergency care and indigent care services; AB 254 does not contain a similar requirement. Since some of these bills' differences appear to create technical conflicts, the authors may wish to adopt appropriate chaptering-out language as the bills progress.

ARGUMENTS IN SUPPORT: The California Women's Law Center (CWLC), a co-sponsor of the bill, is a statewide private nonprofit organization that works to secure the civil rights of women and girls. CWLC states that the frequency and pervasiveness of the expansion of religious health care systems and the affiliations, in particular, between Catholic systems and community and private hospitals have left virtually no community in California unaffected. When a Catholic hospital affiliates with a community or privately controlled facility, usually all medical staff, as condition of employment, must agree to abide by the Religious and Ethical Directives for Catholic Health Care Services. These directives prohibit contraception, sterilization, the distribution of condoms even to prevent the spread of AIDS and sexually transmitted diseases, emergency contraception for rape victims, most fertility treatments, the removal of ectopic pregnancies unless they have become life threatening, and abortion. CWLC notes that the extent to which these Directives are actually enforced is a matter of negotiation between the local bishop and the health system, not between the patient and his or her health care provider.

According to CWLC, the marginalization of these aspects of men's and women's health is in direct conflict with the medical trend toward integration of services and comprehensive care. Moreover, women are being squeezed between the threats of clinic violence when they seek services at stand alone family planning clinics, and are being denied care at mainstream health facilities. According to CWLC, the impact is often felt most harshly in low income neighborhoods and communities of color where the proliferation of religious hospitals is spurred by the Catholic mission to serve the poor. Ironically, however, low income women, who are least able to travel or pay out of pocket for health care, are denied basic services.

CWLC also contends that the denial of these services directly conflicts with standards adopted by the American Public Health Association. APHA has recognized the harm created by the denial of the full range of reproductive health services. According to CWLC, official APHA policy "urges that mergers and affiliations between religious and non-sectarian health systems should not be allowed to create obstacles

that prevent women, men and adolescents from receiving the full range of reproductive health services they need."

Women with private insurance who are in managed care plans also have no choices. When their assigned health care providers refuse to provide reproductive healthcare, these women are forced not only to travel to other facilities, but also to pay for these services out of their pockets. According to CWLC, women pay significantly more out of pocket for their health care, 54%, largely due to the lack of access to family planning services. CWLC argues that it is disingenuous to suggest that men and women and their physicians can always simply choose to go to an alternate site for their health care.

Finally, CWLC notes that many religious hospitals have found creative partnerships with other community resources to ensure that they truly serve the needs of their communities. "AB 525 encourages creative partnerships and collaboration instead of denial of care."

The National Health Law Program (NHeLP), a co-sponsor of the bill, writes that the vast majority of non-elderly women (80%) receiving Medi-Cal are between the ages of 18 and 44, the childbearing ages. According to NHeLP, low-income women on Medi-Cal are being targeted for Medi-Cal managed care enrollment. "Reproductive health services are a critical part of basic, primary care for all women, and for women in this age group in particular. AB 525 will ensure that low-income women, men and adolescents enrolled in Medi-Cal managed care plans have access to these important services."

NHeLP states that "AB 525 will ensure that Medi-Cal managed care and commercial managed care consumers, alike, receive the information that they need about the availability of reproductive health services in order for them to make their health care choices. Up front, clear information is needed at the time that individuals choose their health plans, medical groups, and primary care doctors as well as when they are seeking needed health care services." According to NHeLP, "[I]ndividuals often assume that
reproductive health services are going to be available. Without this information, health care consumers will not be aware that services may be restricted until they are seeking care. This is often too late to make alternative arrangements."

By requiring health plans whose providers restrict access to reproductive health services to contract with at least one other facility in the area that provides services, NHeLP contends the bill ensures that health plans that serve both Medi-Cal and commercial managed care consumers provide accessible choices within their plan networks. "If these services are not easily accessible within the health plan network, women often will not have access to these services at all. Low-income health care consumers, in particular, do not have the time, income, and transportation to seek needed services outside of their health plans (for which services would be reimbursed) or outside of their communities." By requiring that services be accessible, NHeLP believes the bill ensures coordination of care and continuity of care for all of women's primary care services.

The American College of Obstetricians and Gynecologists (ACOG), District IX, which represents over 3,900 California board certified physicians, also supports the bill. According to ACOG, many women's health services are being restricted or eliminated as a result of the growing number of health care facilities in California that are being purchased by religious organizations. "For example, a number of

religious organizations do not believe in sterilization, as a result tubal ligations cannot be performed at the time of labor and delivery. This forces women to locate a hospital and possibly another physician if their own doctor does not have privileges at a hospital accepting their health insurance and allowing tubal ligation." ACOG states that "an inability to have a post partum tubal ligation (sterilization at the time of delivery) means an unnecessary second hospitalization, additional recuperation and risk of additional anesthetic in the same case."

ACOG also contends that in many religious affiliated medical centers, emergency contraceptives are not available for victims of sexual assault. ACOG notes that a 1996 study in *American Journal of Obstetrics and Gynecology* reportedly revealed that 5% - 12% of rapes result in pregnancy. According to ACOG, "[s]ince patients' choice of facilities and physicians is often dependent on health insurance company contracts, women should be guaranteed access to necessary services in reasonable proximity to their home. While we believe that individual conscience should be respected, we do not believe that such beliefs should be extended to systems of care when it limits access to medical care for California women."

Planned Parenthood Affiliates of California (PPAC) supports the bill, stating that one of the recent trends in the health care industry has been the increasing number of nonprofit hospitals that are being acquired by religiously controlled entities, who then limit access to women's health care services based on their religious beliefs. According to PPAC, this has resulted in women across California seeing rapid erosion of their access to basic reproductive health care services, such as contraception, fertility treatments, abortion, and tubal ligation and vasectomy. PPAC notes that when the only hospital left in a community is controlled by a religious institution that doesn't provide these services, women must travel out of their community, and often, out of their county of residence, to access these services. PPAC states that this bill would take an important first step toward preventing this erosion of services by requiring that all health plans guarantee that all patients have access to the full range of reproductive health services within the HMO's health network. PPAC believes that AB 525 will ensure that reproductive health services, protected by the courts and the Legislature, remain available to all California's men and women.

The California Nurses Association supports the bill, stating that it assures access to reproductive services through health plans and will provide significant economic savings as well as social benefits to women and families in general.

The Hedgpeth Group, an organization that works with women's health groups and coalitions serving women's and children's health and social needs, also supports the bill. The Hedgpeth Group states that "[w]ith the continuing 'merger mania' that is affecting hospitals, and with many of those mergers and/or takeovers putting existing community hospitals into the Catholic Healthcare West system, women are losing access to reproductive health services." According to the Hedgpeth Group, it has become apparent over the past several years that the majority of women who are being denied access to reproductive health services tend to be in populations which already lack sufficient health services either because of family location or income.

The Reproductive Rights Coalition-Los Angeles strongly supports the bill, stating that it will protect women and men's access to vital reproductive health services. According to the Coalition, "[t]his legislation will strengthen the communities' involvement in their health care, rights that are critical and long

overdue. The perception that health care is just another market commodity is a dangerous one and undermines everyone's access to health care." The Coalition states that "AB 525 brings health care decision-making back to consumers and the communities in which they live."

Women Lawyers Association of Los Angeles (WLA) also strongly supports the bill, stating that reproductive health services are an essential part of health care to which all individuals should be able to obtain access in all communities throughout the state. WLA states that "[w]ith the merger of so many health care providers in today's managed care environment, the passage of AB 525 is crucial to safeguard against the loss of critically needed reproductive health services in the community and against restrictions on access to these services in hospitals, outpatient facilities, clinics, medical buildings and physician networks." WLA believes that this bill "is an effective and well-reasoned measure to protect the imperative need for women's access to the full range of health services."

ARGUMENTS IN OPPOSITION: The California Association of Catholic Hospitals (CACH) and the Alliance of Catholic Health Care Systems (ACHCS) support those provisions in the bill which seek to prohibit discrimination in the provision of health insurance and health services. However, they oppose the other provisions in the bill unless it is amended. CACH and ACHCS set forth five main reasons for their opposition.

First, they state that they are “unaware of any objective data that support the need for legislation of this scope on this issue.” However, as noted above on pages 5-6 of this analysis, consumers are facing significant barriers in accessing basic, primary care reproductive health services in many communities throughout the state as a result of the increase in the number of religious health care providers in California.

Second, they object to the AG oversight provisions in the bill, claiming that there is no public policy basis in law or fact for the AG's authority to be expanded to review mergers between charitable health care organizations. They also complain that requiring the AG to review whether a merger will “perpetuate” a significant effect on the availability or accessibility to, among other things, abortion, “clearly targets Catholic health care institutions.” CACH and ACHCS also argue that implementation of the bill presents a conflict of interest for the AG, since the AG has the obligation to uphold all of the laws of the state, including the constitutional protections guaranteeing the free exercise of religion. It should be noted, however, that the AG already has authority to oversee nonprofits because of its obligation to ensure that charitable assets are protected. Proponents argue this bill appropriately modifies the AG's authority in this area consistent with the state's interest in ensuring that health care is available to all Californians, including access to critically needed reproductive health care, as well as emergency and indigent care services.

Third, CACH and ACHCS argue that the bill’s public financing provisions are unconstitutional since, they claim, it would financially penalize any nonprofit entity that refuses to provide or arrange for, among other things, abortion. They believe that these provisions, while appearing neutral, unfairly single out for denial of benefits Catholic health care institutions that, by virtue of their religious principles, are fundamentally opposed to providing or assisting in the provision of abortion. They also argue that the denial of tax-exempt financing and bond insurance to Catholic health care institutions will lead to increased costs and a diminution in charity care. However, proponents note the purpose of the bill is to assure access to

reproductive health services; it does not dictate the particular methods for making these basic health services available, and it allows for creative arrangements whereby bond and loan recipients can partner with other groups who will provide these services.

Fourth, they state that the provision in the bill which requires voluntary tubal ligations to be available at the time of labor and delivery is ambiguous since "[i]t does not clearly identify who (i.e., the hospital or the health plan) bears the burden of the obligation to make such voluntary tubal ligations available. They also argue that it is inconsistent with medical practice since, they claim, "doctors that intend on performing voluntary post-delivery tubal ligations on their patients admit them to hospitals other than Catholic hospitals." However, the bill does not require each individual hospital make tubal ligations available at the time of labor and delivery. The authors explain that the point of this provision in the bill is that, with the increased enrollment in managed care, health plans must be responsible for ensuring the ability of doctors and patients to make this choice.

Fifth, CACH and ACHCS oppose the provision which requires health plans to notify prospective and current enrollees of the facilities and providers that restrict access to reproductive health services "because its only practical effect is simply to penalize Catholic health care institutions by requiring health plans to make such disclosures of a purely negative nature." Instead, they argue that this provision in the bill should be restructured to provide more information about where such services are available, consistent with the intent of the legislation. However, according to the authors, most consumers presume that basic primary care includes the full range of reproductive health services and that their doctors and the hospitals they use will make these services available, only to find out later that it is not always the case. The bill requires health plans to give consumers basic information about how to access reproductive health services, including any limitations on accessing these services, so they can make more informed choices when picking their providers.

CACH and ACHCS seek several amendments to the AG provisions in the bill, including: adding a requirement that the AG also evalute whether there would be no significant change in the availability of reproductive health services, and the long-term impact on the availability of the full range of health care services if consent to the merger transaction is denied; requiring that experts or consultants used by the AG must be neutral on the subject matter being reviewed or monitored; and prohibiting the AG from seeking reimbursement of contract costs of reviewing or monitoring a proposed merger or affiliation between two charitable providers. They also recommend deleting the requirement that health plans disclose the identity of facilities and providers that restrict access to reproductive health services. However, CACH and ACHCS have agreed to work with the author in the hope of addressing their concerns in a way which will allow them to modify their position as the bill progresses.

The California Catholic Conference of Bishops (Bishops) oppose the bill, stating that "it would curtail the religious freedom of Catholic hospitals and narrow women's health concerns to reproduction prevention." The Bishops also argue that the bill "may place in jeopardy the ability of these hospitals to continue to provide healthcare for the poor as they have done for over one hundred years." According to the Bishops, the bill tramples on religious freedom rights by "setting up conditions for the operation of Catholic hospitals which would demand a complicity in performance of actions that are in violation to their religious principles." The Bishops further state that if enacted, "the government would be choosing to

disadvantage us by impacting non-profit lending and skewing the market dynamics to accomplish its goals."

Sutter Health is opposed to the provisions in the bill which would give the AG oversight over hospital mergers in nonprofit-to-noprofit transactions. Sutter argues that the bill unnecessarily burdens charity-to-charity transfers and unnecessarily increases hospital expenses by requiring hospitals to pay filing fees, expert witness fees, publication fees, document production fees, consultants' fees and attorney's fees. Sutter also contends that the bill "unnecessarily intrudes the Attorney General into a decision vested in hospital boards and trustees, who are subject to legally enforceable fiduciary duties both before and after a charitable affiliation." In addition, Sutter claims that the bill "would effectively preclude managers from advising their own boards by disabling a manager who exercises the normal responsibilities of his or her office from ever being employed by the transferee charity." Finally, Sutter argues that "[t]he web of burdensome restrictions and fiscal levies imposed by [this bill's AG provisions] simply do not constitute a solution to any demonstrated problem."

The Catholic League for Religious and Civil Rights opposes the bill, stating that it "would punish Catholic hospitals for practicing Church teaching on the sacredness of human life. It would do this by denying funds to Catholic hospitals that are collected through the sale of revenue bonds." According to the Catholic League, the bill is "not only inimical to Catholic interests and to the First Amendment, it is inimical to the public interest as well." However, proponents note that the Catholic League's arguments appear to be misplaced since, as noted above, nothing in the bill requires a religious provider to provide services inconsistent with their religious beliefs. The bill provides that if health care providers wish to take advantage of taxpayer dollars through various public financing programs, they must provide assurances that reproductive health services will be made available in the local community. Proponents note the bill does not dictate how these services should be made available; it gives flexibility to the health facilities by allowing them to enter into creative partnerships with other organizations and groups who may deliver or otherwise arrange for the provision of these services.

Related Pending Legislation. AB 254 (Cedillo), which, as noted above, contains similar provisions expanding AG oversight over nonprofit-to-nonprofit hospital transfers, is currently scheduled to be heard in the Assembly Judiciary Committee on April 6, 1999.

AB 351 (Steinberg), which gives the AG similar oversight over HMO mergers, is also scheduled to be heard in the Assembly Judiciary Committee on April 6, 1999.

Prior Legislation. AB 3101 (Isenberg), Ch. 1105, Stats. 1996, which provided the AG with greater oversight and regulatory authority over the sale or other disposition of assets between non-profit and for-profit health facilities.

AB 2527 (Cedillo - 1998), which was substantially similar to AB 254 (discussed above), was vetoed.

REGISTERED SUPPORT / OPPOSITION:

Support

California Women's Law Center (co-sponsor)
National Health Law Program (co-sponsor)
American College of Obstetricians and Gynecologists
Asian Law Alliance
Asians & Pacific Islanders for Reproductive Health
The Birthing Project
California Family Health Council
California National Organization for Women
California Nurses Association
California Primary Care Association
California School Employees Association
California Women Lawyers
California Women's And Children's Health Coalition
Catholics for a Free Choice
The Feminist Majority
Hadassah (Sacramento Chapter)
The Hedgpeth Group
Maternal and Child Health Access
National Center For Youth Law
National Council Of Jewish Women
National Latina Health Organization
Natividad Medical Center, Medical Staff
Northern California Lawyers for Civil Justice
The Pacific Institute for Women's Health
Planned Parenthood Affiliates of California
Planned Parenthood of Santa Barbara, Ventura and San Luis Obispo
Reproductive Rights Coalition - Los Angeles
Unitarian Universalist Service Committee, Project Freedom of Religion
Women's Health Specialists (Chico, Redding, Sacramento, Santa Rosa clinics)
Women Lawyers Association of Los Angeles
various individuals

Opposition

Alliance of Catholic Health Care Systems & California Association of Catholic Hospitals (unless amended)
California Catholic Conference of Bishops
Catholic League for Religious and Civil Rights
Sutter Health (to AG asset transfer provisions)

Analysis Prepared by: Daniel Pone / JUD. / (916) 319-2334